MDR Tracking Number: M5-04-2208-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 02-04-04.

The IRO reviewed osteopathic medicine, nerve conduction study each nerve, neuromuscular stimulator electric, electrodes, FCE and sensory test each nerve rendered from 02-24-03 through 06-30-03 that were denied based upon "V".

The IRO determined that the use of the neurostimulator **was not** medically necessary for dates of service 02-24-03 through 06-30-03. The IRO determined that the NCV/EMG and chiropractic care from 02-24-03 through 06-30-03 **was** medically necessary. The requestor raised no other reasons for denying reimbursement for the above listed services.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the **majority** of issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 12-07-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

HCPCS code E0745 dates of service 02-24-03, 03-29-03, 04-30-03 and 05-30-03 denied with denial code "N" (not appropriately documented). The requestor did not submit information to meet documentation criteria. No reimbursement is recommended.

HCPCS code A4556 dates of service 02-24-03, 03-29-03, 04-30-03 and 05-30-03 denied with denial code "N" (not appropriately documented). The requestor did not submit information to meet documentation criteria. No reimbursement is recommended.

## ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 03-04-03 through 06-30-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Findings and Decision and Order are hereby issued this 21st day of December 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

November 2, 2004

Ms. Rosalinda Lopez
Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

## NOTICE OF INDEPENDENT REVIEW DECISION
## Amended Letter B

**RE: MDR Tracking #: M5-04-2208-01**
**TWCC #:**
**Injured Employee:**
**Requestor: Mid Cities Neuro Lab**
**Respondent: Chubb Insurance**
**MAXIMUS Case #: TW04-0145**

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation

provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the MAXIMUS external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in occupational and general preventive medicine and public health, and is familiar with the condition and treatment options at issue in this appeal. The MAXIMUS physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 54 year-old female who sustained a work related injury on ___. The patient reported that while at work she sustained a cumulative repetitive injury to her neck, left shoulder, left wrist and left hand. X-rays of the spine, shoulder & wrists were performed on 10/24/02. On 11/19/02 the patient underwent a MRI of the left wrist and cervical spine. An orthopedic evaluation note dated 1/6/03 indicated that the assessment for this patient was left carpal tunnel and cubital tunnel syndrome, left DeQuervain's syndrome, and left lateral epidonylitis. It indicated that the patient had undergone an EMG/NCV testing in the past, however a current EMG/NCV would be repeated. It also indicated that the patient had been treated with medications and extensive physical therapy. Another orthopedic evaluation dated 3/20/03 indicated that x-rays of the left shoulder showed narrowing of the A-C joint with spurring at its inferior surface. It also noted that the assessment for this patient was left A-C arthropathy. On 4/2/03 the patient underwent arthroscopic surgery of the left shoulder. A follow up orthopedic evaluation dated 4/7/03 indicated that the patient would be referred for postoperative therapy daily for four weeks, providing gradual improvement is experienced.

Requested Services

Osteopathic med, nerve conduction study EA nerve-any/all, and FCE from 2/24/03 through 6/30/03.

Documents and/or information used by the reviewer to reach a decision:

*Documents Submitted by Requestor*:

1. Initial exam (no date), SOAP notes 1/17/03
2. MRI report cervical spine/left wrist 11/19/02
3. X-Ray report spine, shoulder & wrists 10/24/02
4. Pain consultation 1/25/03
5. Orthopedic notes 1/6/03 – 10/9/03
6. Neuro Selective CPT Lab Report 3/12/03
7. Range of motion exams 4/22/03 and 3/3/03

*Documents Submitted by Respondent*:

1. RME/FCE 8/13/03
2. Peer reviews 1/16/03, 1/8/03, 1/13/03, 4/9/03, 3/25/03, 4/5/03

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a female who sustained a work related injury on ___.

The MAXIMUS physician reviewer noted that the treating physician recommended an FCE every 4-6 weeks to assess improvement with recommended treatment. The MAXIMUS physician reviewer explained that traditionally, the physician assessment is sufficient to note big improvements in function, especially range of motion assessment. The MAXIMUS physician reviewer indicated that it is not necessary to note changes in single digit degrees in range of motion because it has little clinical significance. The MAXIMUS physician reviewer explained that a functional capacity evaluation is often done at the conclusion of all treatments, to better understand any residual impairment.

The MAXIMUS physician reviewer explained that it is important to obtain additional electrodiagnostic testing during the period in question, since the patient had evidence of possible median nerve entrapment over a period of months. The MAXIMUS physician reviewer indicated that there was clearly documented evidence of carpal tunnel syndrome, including positive Phalen's, Flick's and Tinel's signs. The MAXIMUS physician reviewer explained that a negative EMG alone is not diagnostically appropriated for a diagnosis of carpal tunnel syndrome, which has early sensory findings, not motor, which is often documented on nerve conduction studies (not EMG).

The MAXIMUS physician reviewer indicated that many of the chiropractic modalities and treatments described are shared with physical therapy. The MAXIMUS physician reviewer explained that the surgeon recommended physical therapy for the patient in an attempt to regain her range of motion. The MAXIMUS physician reviewer noted that there are no therapy notes submitted outside of the chiropractic care notes, so it is assumed that the chiropractor served in this capacity. The MAXIMUS physician reviewer also explained that any chiropractic specific treatment such as manipulation of the shoulder would be outside of the scope of the physical therapy prescribed. Therefore, the MAXIMUS physician consultant concluded that the NCV/EMG, FCE and chiropractic care from 2/24/03 through 6/30/03 were medically necessary to treat this patient's condition.

Sincerely,
**MAXIMUS**

Elizabeth McDonald
State Appeals Department